



Department of Pesticide Regulation



Paul Helliker
Director

Arnold Schwarzenegger
Governor

March 17, 2004

WHS 04-02

TO: COUNTY AGRICULTURAL COMMISSIONERS
SUBJECT: REVISED MEDICAL INFORMATION AUTHORIZATION FORMS

Congress called on the United States Department of Health and Human Services (HHS) to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In response, HHS developed new regulations to protect the security and confidentiality of health information. These new regulations became effective on April 14, 2003.

The Medical Information Authorization forms, dated 9/94, are not in compliance with HIPAA regulations. In order to comply with the HIPAA regulations, the Department of Pesticide Regulation (DPR) revised the Medical Information Authorization forms in February 2004 (PR-ENF-133 [English] and PR-ENF-133x [Spanish] Rev. 2/04).

The Enforcement Branch is in the process of printing new forms that should be available for distribution in 2-3 weeks. Please submit a form requisition request to the Enforcement Branch to order these forms. DPR recommends you discard any outdated Medical Information Authorization forms (dated 9/94 or older) to ensure you are in compliance with HIPAA regulations. If you need a Medical Information Authorization form before you receive your order, please print and use the enclosed forms. If you use a printed copy, please be sure the person signing the form gets a copy.

If you have any questions regarding the basis for the changes to the form, please contact Ms. Sue Edmiston of my staff at (916) 445-4278, or sedmiston@cdpr.ca.gov.

Sincerely,

[ORIGINAL SIGNED BY C. ANDREWS]

Charles M. Andrews, Chief
Worker Health and Safety Branch
(916) 445-4222

Enclosures

cc: Mr. Daniel J. Merkley, Agricultural Commissioner Liaison
Mr. Roy Rutz, Agriculture Program Supervisor III
Ms. Susan Edmiston, Agriculture Program Supervisor III
Mr. Donald M. Richmond, Associate Environmental Research Scientist



MEDICAL INFORMATION AUTHORIZATION

PHYSICIAN OR HOSPITAL

I hereby authorize

ADDRESS _____

CITY, STATE AND ZIP CODE _____

NAME OF RECIPIENT OR RESPONSIBLE AGENCY _____

to furnish to

ADDRESS _____

CITY, STATE AND ZIP CODE _____

Medical records and all information pertinent to medical care, treatment, hospitalization and/or outpatient care received by (self, child, or ward) _____ in regard to (describe incident) _____

which occurred in _____ county on (date or dates) _____

- I understand the purpose of providing this information is to assist in the investigation of the above incident, and any associated legal or administrative action connected with the incident.
- I understand that this information will be used by the County Agricultural Commissioner's office in the above-listed county and by the Department of Pesticide Regulation. Such release will aid in the investigation of the incident described above.
- I understand information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality laws (HIPAA). However, under the Information Practices Act of 1977 (California Civil Code § 1798 et seq.), the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law pursuant to state confidentiality laws.
- This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- This authorization expires six months after the date of signature, or as specified _____.
- I have received a copy of this authorization.
- A photocopy of this authorization may be used the same as the original.

AUTHORIZING SIGNATURE (MAY BE SIGNED INDIVIDUALLY OR AS PARENT OR GUARDIAN)

DATE _____

N
WITNESS

DATE _____

N

MÉDICO U HOSPITAL

Por este medio yo autorizo

DIRECCIÓN

CIUDAD, ESTADO Y CÓDIGO POSTAL

NOMBRE DEL RECIBIDOR O AGENCIA RESPONSABLE

para proporcionar a

DIRECCION

CIUDAD, ESTADO Y CÓDIGO POSTAL

Registros médicos y toda la información relacionada con el cuidado médico, tratamiento, hospitalización y/o paciente externo (que no queda en el hospital o clínica), cuidado recibido por (propio, niño, o menor bajo tutela) _____ con relación a (describir el incidente)

Que ocurrió en el condado de _____ en (fecha o fechas) _____

- Yo entiendo que el propósito de entregar esta información es para asistir en la investigación del incidente mencionado arriba, y cualquiera acción legal o administrativa relacionada con el incidente.
- Yo entiendo que esta información será usada por la oficina del Comisionado Agrícola del Condado y en el condado mencionado en la lista de arriba, y también por el Departamento de Reglamentación de Pesticidas. Tal declaración, ayudará en la investigación del incidente descrito arriba.
- Yo entiendo que la información revelada de acuerdo con esta autorización, podría ser revelada nuevamente por el receptor y no estaría protegida por más tiempo bajo las leyes federales de confidencialidad (HIPPA, por su sigla en inglés). Sin embargo, bajo la Ley de 1977 de las Prácticas de Información (Código Civil de California § 1798 et seq.), el solicitante en adelante, no puede usar ni tampoco revelar la información médica. Salvo que se obtenga de mí otra autorización, o a menos que tal uso o declaración se requiera o se permita específicamente por ley, de acuerdo a las leyes estatales de confidencialidad.
- Esta autorización puede ser cancelada en cualquier momento. Mi cancelación será efectiva en el momento de recibirla, pero no tendrá efecto en usos o declaraciones hechas mientras mi autorización era válida.
- Esta autorización expira seis meses después de la fecha de mi firma, o como se especifique _____
- Yo recibí una copia de esta autorización.
- Una fotocopia de esta autorización puede usarse en lugar del original.

FIRMA AUTORIZADORA (PUEDE FIRMAR INDIVIDUALMENTE O COMO PADRE O TUTOR)

FECHA

N
TESTIGO

FECHA

N

DISTRIBUCIÓN:

ARCHIVO – BLANCO

COLOR CANARIO – MÉDICO U HOSPITAL

ROSADO – FIRMA AUTORIZADORA O PACIENTE